Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PATIENTS MEDICAL CENTER
3701 KIRBY DR STE 1288
HOUSTON TX 77098-3900

Respondent Name
Facility Insurance Corp

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-0340-01

MFDR Date Received
September 23, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier in this case chose to access a First Health contract that provided for a discount of 10% off the Texas Workers' Compensation Fee Schedule and full charges if the bill is not properly paid in a timely fashion. Using the contract, the hospital would have been entitled to full billed charges as a result of Carrier's refusal to properly pay this claim in a timely manor. Therefore, the Provider contends an additional $92,285.73 remains owed."

Amount in Dispute: $92,285.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier believes that the correct reimbursement rate is $2354.75 which has already been tendered to the provider. No additional reimbursement is due."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2009	Outpatient Hospital Services	$92,285.73	$20,495.78

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 9, 2010
   - ZHX-001 FROM CONVERSION, PPO SAVINGS
   - ZHX-002 FROM CONVERSION, PRICE SAVINGS
   - ZTX-198 198 PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION
   - ZTX-F00 A2-CONTRACTUAL ADJUSTMENT ANY REDUCTION IS IN ACCORDANCE WITH THE FOCUS/AETNA WORKER'S COMP ACESS LLC CONTRACT. FOR QUESTIONS REGARDING REDUCTIONS. PLEASE CALL 1-800-238-8288
   - ZTX-F W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. FEE GUIDELINE MAR REDUCTION
   - ZTX – PAY 217 – BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT. REDUCE TO FAIR AND REASONABLE
   - ZTX-TXA W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. PRICED ACCORDING TO THE STATE APC FEE SCHEDULE RATE.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Did the respondent support the insurance carrier's reason for denying procedure code 63688?
4. Did the respondent support the insurance carrier's reason for denying procedure code C1820?
5. What is the recommended payment amount for the services in dispute?
6. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code ZTX-F00 "A2-CONTRACTUAL ADJUSTMENT ANY REDUCTION IS IN ACCORDANCE WITH THE FOCUS/AETNA WORKER'S COMP ACESS LLC CONTRACT. FOR QUESTIONS REGARDING REDUCTIONS. PLEASE CALL 1-800-238-8288" Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on November 3, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the healthcare provider had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested
3. The insurance carrier denied disputed surgical services billed under procedure code 63688 with reason code ZTX-198 – "PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION." Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." No documentation was found to support a medical emergency, nor was any documentation found to support that this surgical service had been preauthorized. The insurance carrier's denial reason is supported. Reimbursement for procedure code 63688 is not recommended.
4. The insurance carrier denied a disputed implantable surgical supply item billed under procedure code C1820 with reason code ZTX-198 – "PAYMENT DENIED/REDUCED FOR EXCEEDED

PRECERTIFICATION/AUTHORIZATION." Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." 28 Texas Administrative Code §134.403(d) requires that "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided." Per Medicare policy, payment for the surgical implantable supply item is included in the reimbursement for surgical services that had been preauthorized by the insurance carrier. Review of §134.600(p) does not find implantable surgical supply items enumerated among the health care requiring preauthorization. Review of the submitted information finds no documentation to support this denial reason. Procedure code C1820 will therefore be reviewed per applicable Division rules and fee guidelines.

5. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code J1100, date of service September 23, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J2250, date of service September 23, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J3010, date of service September 23, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J2405, date of service September 23, 2009, has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. These services are classified under APC 0768, which, per OPPS Addendum A, has a payment rate of $0.20. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.12. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $0.12. The non-labor related portion is 40% of the APC rate or $0.08. The sum of the labor and non-labor related amounts is $0.20 multiplied by 2 units is $0.40. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total APC payment for this line is $0.40. This amount multiplied by 200% yields a MAR of $0.80.
   - Procedure code C1778, date of service September 23, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code C1883, date of service September 23, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 77003, date of service September 23, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 63660, date of service September 23, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0687, which, per OPPS Addendum A, has a payment rate of $1,297.25. This amount multiplied by 60% yields an unadjusted labor-related amount of $778.35. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $769.79. The non-labor related portion is 40% of the APC rate or $518.90. The sum of the labor and non-labor related amounts is $1,288.69. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list

a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2009 Default CCR as 0.2379. This ratio multiplied by the billed charge of $2,558.75 yields a cost of $608.73. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,288.69 divided by the sum of all APC payments is 84.93%. The sum of all packaged costs is $20,649.75. The allocated portion of packaged costs is $17,537.66. This amount added to the service cost yields a total cost of $18,146.39. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $15,891.18. 50% of this amount is $7,945.59. The total APC payment for this line, including outlier payment, is $9,234.28. This amount multiplied by 200% yields a MAR of $18,468.56.

- Procedure code 95972, date of service September 23, 2009, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0692, which, per OPPS Addendum A, has a payment rate of $109.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $65.54. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $64.82. The non-labor related portion is 40% of the APC rate or $43.70. The sum of the labor and non-labor related amounts is $108.52. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2009 Default CCR as 0.2379. This ratio multiplied by the billed charge of $2,558.75 yields a cost of $608.73. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $108.52 divided by the sum of all APC payments is 7.15%. The sum of all packaged costs is $20,649.75. The allocated portion of packaged costs is $1,476.84. This amount added to the service cost yields a total cost of $2,085.57. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,895.66. 50% of this amount is $947.83. The total APC payment for this line, including outlier payment, is $1,056.35. This amount multiplied by 200% yields a MAR of $2,112.70.
- Procedure code 62273, date of service September 23, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0206, which, per OPPS Addendum A, has a payment rate of $241.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $144.67. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $143.08. The non-labor related portion is 40% of the APC rate or $96.44. The sum of the labor and non-labor related amounts is $239.52. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2009 Default CCR as 0.2379. This ratio multiplied by the billed charge of $2,558.75 yields a cost of $608.73. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $119.76 divided by the sum of all APC payments is 7.89%. The sum of all packaged costs is $20,649.75. The allocated portion of packaged costs is $1,629.80. This amount added to the service cost yields a total cost of $2,238.53. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $2,028.95. 50% of this amount is $1,014.48. The total APC payment for this line, including outlier payment and multiple-procedure discount, is $1,134.24. This amount multiplied by 200% yields a MAR of $2,268.47.

6. The total allowable reimbursement for the services in dispute is $22,850.53. This amount less the amount previously paid by the insurance carrier of $2,354.75 leaves an amount due to the requestor of $20,495.78. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $$20,495.78.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $$20,495.78 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	March 13, 2013
Signature	Medical Fee Dispute Resolution Officer	Date
_____	_____	March 13, 2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.